"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

DIVISION OF DISABILITY AND REHABILITATIVE SERVICES
402 W. Washington Street, P.O. Box 7083
Indianapolis, IN 46207-7083
1-800-545-7763

September 15, 2005

Dear Provider,

The Annual Plan project, announced by Governor Daniels and FSSA Secretary Mitch Roob on August 12, begins today. This is the first step in a longer journey to reform a system that has been described as "broken" by consumers, providers, and state staff alike. This is an opportunity for us to partner together to reduce bureaucratic red tape and costs, while generating savings that will allow us to start providing services to individuals who have been waiting many years.

This letter serves as the official notification of billing, policy and administrative procedure changes for providers of services to individuals on the Developmental Disabilities, Support Services and Autism waivers. Changes announced today will go into effect on November 1, 2005.

We have assembled this informational packet in order to ease the transition process to the new system. In a separate document, to be e-mailed the week of September 26th, providers impacted by these service changes will be sent the rate information for each individual.

We want to encourage the development of innovative service technologies and business models to more effectively serve a larger number of individuals with developmental disabilities. These billing changes do allow you to be flexible in how most services are delivered. It will be critical for you, as a provider, to take advantage of these opportunities to reduce your costs and increase your capacity to serve. The State will be working with industry representatives to sponsor the development of innovative approaches to service provision.

We understand that with any change of this magnitude there will be questions and the need for further clarification. The Division is planning several opportunities for providers, families, and individuals served to get answers.

The intent of this effort is to create an environment in which we all can spend more time with individuals we serve and less time on paperwork.
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Sincerely,

Peter A. Bisbecos

Peter A. Bisbecos
Director

Meeting Schedule

BDDS Provider Meetings	Case Manager Training
September 27, 2005 9:30 – 11:30 am Floyd County Library New Albany, IN	**September 27, 2005** 12:30 – 2:30 pm Floyd County Library New Albany, IN
September 28, 2005 10:00 am -12:00 pm St. Vincent New Hope 8450 N Payne Road, Indianapolis, 46268 Indianapolis, IN	**September 30, 2005** 10:00-12:00 pm Indiana Government Center South Conference Room B Indianapolis, IN
October 6, 2005 9:30-11:30 am Evansville Public Library Evansville, IN	**October 6, 2005** 12:30 – 2:30 pm Evansville Public Library Evansville, IN
October 11, 2005 10:00 am – 12:00 pm Ft. Wayne State Developmental Center – Auditorium Ft. Wayne, IN	**October 11, 2005** 1:00-3:00 pm Ft. Wayne State Developmental Center – Auditorium Ft. Wayne, IN
October 14, 2005 9:30-11:30 am Southlake Community Mental Health Merrillville, IN	**October 14, 2005** 12:30 – 2:30 pm Southlake Community Mental Health Merrillville, IN

PROJECT OVERVIEW

In order to explain the Annual Plan and document changes to the billing system we provide this overview that details the following information:

- Conversion of existing budgets.
- Revised service definitions for Residential Habilitation and Support Services, Day Services, Behavioral Support Services, and Case Management.
- Rate setting for each new service.
- Billing summary and new documentation standards.
- Provider requirements and certification for new and existing services.
- The role of quality assurance and the audit process.

Conversion Process

All active Plans of Care/Cost Comparison Budgets (CCBs) will be end dated on October 31, 2005 and new automatically generated CCBs will go into effect on November 1, 2005. The week of September 26, 2005 providers impacted by the changes described here will receive information detailing the specific rate for each individual. The week of October 10, 2005, your organization will receive new Notices of Action developed for the implementation of the Annual Plan project. The start date will be November 1, 2005 and the end date will be the same as the end date of the individual's current CCB.

Services that fall into the revised service areas will appear on the Notice of Action with the new unit, rate and annual allocation. Services that are not included in the revised service definitions will be pulled directly from the current CCB. These services are listed in Attachment B. We will provide several training opportunities on the new CCB process for Case Managers.

Revised Services, Units and Rates

Definitions for the revised services of Residential Habilitation and Supports, Day Services, Case Management and Behavioral Support Services can be found in Attachment A. Not all services or billing codes will be affected by this project. Through the Annual Plan process, several billing codes will be eliminated. These services have been rolled into the four revised services. An overview of the new service codes and end-dated service codes can be found in Attachment B.

Individuals that started the waiver on July 1, 2005 or after will have rates for services determined by state staff. State staff will assess the needs of the individual as described by the case manager in the CCB and designate a rate for each service area (Residential Habilitation and Support, Day Services and Behavioral Support Services) that is comparable to others receiving services with similar outcomes and staffing requirements. Specific unit amounts for services not impacted by this project will also be determined by state staff.

Residential Habilitation and Supports

The new unit and rate for Residential Habilitation and Supports (RHS) will reduce the need for constant budget requests to modify the .25 hour unit allocation. The new RHS billing unit will be an annual rate paid on a daily basis. The new rates will be specific to each individual and will be determined by applying a tiered rate system derived from actual Residential Habilitation and Supports services delivered by and paid to the provider between July 1, 2004 and June 30, 2005. RHS paid at all levels (1, 2 and 3) will be totaled for this time period and divided by 365. The new daily rate will then be determined as follows:

Current RHS Daily Rate	Percent Reduction	New Daily Rate
$0 - $161	No Reduction	100% of Prior Yr Expenditures
$162 - $179	1-2% Reduction	Up to 99% of Prior Yr Expenditures
$180 - $197	2-3% Reduction	Up to 98% of Prior Yr Expenditures
$198 - $249	3-5% Reduction	Up to 97% of Prior Yr Expenditures
$250 - $299	6-7% Reduction	Up to 94% of Prior Yr Expenditures
$300 - $349	8-9% Reduction	Up to 92% of Prior Yr Expenditures
$350 - $450	9-10% Reduction	Up to 91% of Prior Yr Expenditures
$451 and above	Case by Case review	Case by Case Review

The new RHS per diem rate will also incorporate the amount paid by the state during the 2005 fiscal year for the current services of Health Care Coordination (HCC), Transportation provided by the residential provider, and Community Habilitation and Participation Individual (CHPI) provided by the residential provider. No reductions will be taken from the actual paid amounts for HCC, Transportation or CHPI services. The per diem will be billed by the residential provider who will be responsible for arranging HCC and Transportation services. If an individual is receiving services from more than one residential provider, the provider listed on the current CCB as providing the higher dollar amount of service will be the provider designated to get the per diem. Please see Attachment A for a detailed definition of the revised RHS service.

Day Services

A new per diem rate for Day Services will eliminate the gridlock created by 15 minute billing increments. The Day Service per diem for each individual will include the amount paid by the state during the 2005 fiscal year for each of the following services: Supported Employment Follow Along, Pre-Vocational Services, Transportation provided by the day service provider and all types of Community Habilitation and Participation provided by the current day service provider. No reductions will be taken from the actual paid claims for these services. Please see Attachment A for a detailed definition of this service.

For those individuals that have multiple day service providers, the state will pay the day service per diem (for that individual) to the provider that receives the larger dollar amount of funding on the current CCB. Only that provider will be able to bill for that individual. Agreements between providers that permit the individual to continue receiving services as they do today are strongly encouraged.

Behavioral Support Services

Behavior Support Services will continue to be paid through two services, Behavior Management (BMAN) and Behavior Management Level 1 (BMAN1). Both will be paid as a monthly rate. New rates for these services will be based on the actual amounts paid between July 1, 2004 and June 30, 2005, less an 8% reduction. That amount will be divided by 12 to equate a monthly rate. Please see Attachment A for the revised service definition.

Case Management

The role of Case Managers will change as a result of the Annual Plan. With changes to the budgeting process, case managers will no longer need to constantly update CCBs. For billing purposes, Case Management will be divided into two units, one for an Annual Review and one for ongoing, monthly case management. On the DD and Autism waivers, the Annual Review will be paid at $250 and the monthly rate will be $140. On the Support Services waiver, the Annual Review will be paid at $250 and the monthly rate will be $75. Case Management rates for individuals with no paid claims history and those new to the waivers will be the same set monthly amounts. Please see Attachment A for a detailed definition of this service.

The Annual Review is comprised of an annual verification of level of care and a review of the ISP to assure that it continues to be appropriate. Specific information on CCB submission after November 1, 2005 will be presented in training sessions for Case Managers held through out the State. Please see the specific dates and locations in the cover letter.

These changes in case management are an interim step as we plan to release an RFP for Case Management Services before December 15, 2005. We plan to have Case Management services under the RFP in effect as soon as possible.

Other Services

All current services not included in these revised service definitions will remain as they are today with the same units and unit rates. For the annual plan conversion, these services and units will look as they do on the currently approved CCB.

Note about the Support Services Waiver: There are a small number of individuals that receive Health Care Coordination on the Support Services Waiver. Since RHS is not offered on the Support Services Waiver and Health Care Coordination is typically offered in conjunction with residential type services, this service will be ended on the SSW as of

October 31, 2005. Case Managers for the individuals affected will receive notification and instructions on how to proceed.

Billing and Documentation Standards
The changes in service definitions allow us to simplify services into fewer billing codes and allow you to bill at a consistent rate for each service. Documentation requirements for RHS and Day Services have also been simplified. Please see attachments C & D which detail the new process for billing and the required documentation.

In addition to billing changes, we are introducing a policy that addresses provider selection. The Service Provider Selection Policy will be released on October 1, 2005. Individuals will now select a provider at the time of enrollment or each year when their annual plan is completed. Provider changes during the annual plan period will be allowed only in exceptional circumstances. Exceptions to this policy are health and safety concerns that require state involvement such as, provider decertification or a substantiated case of abuse or neglect. This new policy will be released on October 1, 2005.

Provider Requirements and Certification
We understand that providers have been certified by the state to provide specific services. With the update in service definitions, some providers may find themselves providing some aspect of a service that they have not provided before (such as transportation). This is especially critical for RHS and Day Service providers. The state holds these providers accountable for the health and safety of the individual when in their care.

The revised service of Residential Habilitation and Support will continue to be provided by those approved to provide current RHS services. At this time, the State will not go through an additional provider certification process. However, by providing RHS, the provider agrees to assure the health oversight and transportation needs of the individuals they serve by meeting the requirements currently outlined in 460 IAC for the services of Health Care Coordination (460 IAC 6-5-14) and Transportation (460 IAC 6-5-30). When you provide these services you must provide them in a manner that is approved by the state and you will be held accountable for the standard of all services delivered.

Current providers of Supported Employment Follow Along, Pre-Vocational services, Community Habilitation and Support Facility-Group, Facility-Individual, Community-Group and Community-Individual are approved to provide services under the new Day Service definition. This new service increases flexibility of providers and Individual Support Teams to meet the needs of the individual in Day Services regardless of the location, setting or activity. Those providers that offer community-based employment related services must continue to have the appropriate accreditation. By providing Day Services, the provider agrees to assure the transportation needs of the individuals they serve by meeting the requirements currently outlined in 460 IAC for the service of Transportation (460 IAC 6-5-30). When you provide services you must provide them in a manner that is approved by the state and you will be held accountable for the standard of all services delivered.

Case Managers are required to provide Person Centered Planning to individuals they serve. Case Managers that are not trained and approved in facilitating the PCP process must make arrangements with a trained facilitator in order to best meet the needs of the individuals they serve.

Quality Assurance and Audit Process

BQIS and the EDS Audit Unit have been involved in the decision and planning process these changes. The health, safety and welfare of the individual continue to be of utmost importance and while the survey process will continue to reflect that, it will also incorporate changes to bring it in line with the administrative simplification goals of this project. The standards and practices for the service outlined in this document will be the basis for surveys and audits for these services done after November 1, 2005. The incident report process will not change at this time. However, efficiencies in this process are being explored.

Quality assurance for the waiver program will continue to focus on achievement and progress toward outcomes established in the ISP. Metrics for measuring the success of individuals in meeting their outcomes must become an important part of the ISP development process.

ATTACHMENT A: New Service Definitions

Behavioral Support Services	Behavioral Support Services means training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors
Unit of Service	Level 1 Clinician - monthly rate based on the needs of the individual Level 2 Clinician – monthly rate based on the needs of the individual
Activities Allowed	Reimbursable activities of Behavioral Support Services include: • Observation of the individual and environment for purposes of development of a plan and to determine baseline • Development of a behavioral support plan • Obtain consensus of the Individualized Support Team that the behavioral support plan is feasible for implementation • Training in assertiveness • Training in stress reduction techniques • Training in the acquisition of socially accepted behaviors • Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavioral support plan • Consultation with team members • Consultation with HSPP
Activities Not Allowed	The following activities are not allowed under Behavioral Support Services: • Aversive techniques

- Any techniques not approved by the individual's person centered planning team and the provider's human rights committee

- In the event that a Level 1 clinician performs Level 2 clinician activities, billing for Level 1 services is not allowed. In this situation, billing for level 2 services only is allowed

Service Standards

Behavioral Support Services must be recognized as needed and appropriate in the Individualized Support Plan (ISP)

- Services must address needs identified in the person centered planning process and be outlined in the ISP

- The behavior supports specialist will observe the individual in his/her own milieu and develop a specific plan to address identified issues

- The behavior supports specialist must assure that Residential Habilitation and Supports direct service staff are aware of and are active participants in the development and implementation of the Behavior Support Plan

- The behavior plan will meet the requirements stated in 460 IAC 6-18-2

- The behavior supports provider will comply with all specific standards in 460 IAC 6-18

- Any behavior supports techniques that limit the individual's human or civil rights must be approved by the person centered planning team and the provider's human rights committee. No aversive techniques may be used

- Chemical restraints and medications prescribed for use as needed (PRN) meant to retrain the individual shall be used with caution. The use of these medications must be approved by Individualized Support Team (IST) and the appropriate human rights committee

- The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary

- The behavior specialist will provide a written

report to pertinent parties at least quarterly. "Pertinent parties" includes the individual, guardian, BDDS service coordinator, waiver case manager, all service providers, and other involved entities

Provider Qualifications

To be approved to provide Behavioral Support Services as a licensed Level 1 clinician:

- An applicant shall be a licensed psychologist under IC 25-33 and have an endorsement as a health service provider in psychology pursuant to IC 25-33-1-5.1(c)

To be approved to provide Behavioral Support Services as a licensed Level 2 clinician an applicant shall meet the following requirements:

- (1) Either:
  - (A) have a master's degree in:
    - (i) psychology;
    - (ii) special education; or
    - (iii) social work; or
  - (B) meet all of the following requirements:
    - (i) Have a bachelor's degree
    - (ii) Be employed as a behavioral consultant on or before September 30, 2001, by a provider of behavioral support services approved under 460 IAC 6
    - (iii) Be working on a master's degree in psychology, special education or social work
    - (iv) By December 31, 2006, complete a master's degree in psychology, special education, or social work

- (2) Be supervised by a Level 1 clinician

To maintain approval as a Behavioral Support Services provider, a Behavioral Support Services provider shall:

- (1) Obtain annually at least ten (10) continuing education hours related to the practice of behavioral support:

- (A) From a Category I sponsor as provided in 868 IAC 1.1-15; or
- (B) As provided by the BDDS's behavioral support curriculum list; or

- (2) Be enrolled in:
  - (A) a master's level program in psychology, special education, or social work; or
  - (B) A doctoral program in psychology

For an entity to be approved to provide Behavioral Support Services, the entity shall certify that, if approved, the entity shall provide Level 1 clinician behavioral support services or Level 2 clinician behavioral support services using only persons who meet the qualifications set out in 460 IAC 6-5-4

Beginning July 1, 2004, a provider of Behavioral Support Services who:
• (1) prepares a behavioral support plan; or
• (2) implements a behavioral support plan; shall cooperate with the division's or the BDDS's regional human rights committee for the geographic area in which the provider is providing services under 460 IAC 6

Documentation Standards

Behavioral Support Services documentation must include:

Level 1 Clinician

- Services outlined in ISP
- Behavioral Support Plan
- Data record documenting the service performed, i.e., diagnosis; behavior plan review; staff training; individual intervention; consultation with Level 2 Clinician, etc.
- Documentation in compliance with 460 IAC 6
- This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider agreement and reimbursement for services will not be available

Level 2 Clinician

- Services outlined in ISP
- Behavioral Support Plan signed by Level 1 clinician
- Data record of documenting the service performed, i.e., behavior plan writing/editing; staff training; individual intervention; consultation with HSPP, etc.
- Monthly report by QMRP or Behavior Specialist of behavioral progress
- Documentation in compliance with 460 IAC 6
- This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider agreement and reimbursement for services will not be available

This service definition is effective 11-01-05
This service definition supersedes all previous definitions of this service

Day Services	Day Services means services outside of an individual's home that support, in general, learning and assistance in any of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living, including development of employment skills. These activities are directly related to the Individualized Support Plan (ISP). Each individual receiving Day Services works toward acquiring the skills to become an active member of the community. The continuum of services within Day Services provides opportunities in facility based and the community based services to become more independent and more integrated within community activities. Day Services can be delivered to an individual one-on-one or in a group setting and in the community, work setting, or facility.
Unit of Service	Daily rate based on the needs of the individual
Activities Allowed	Direct supervision, monitoring, training, education, demonstration or support to assist with • An individual's personal needs (feeding, toileting, etc.) • Transportation (excluding transportation that is covered under the Medicaid State Plan) • Acquisition, improvement and retention of daily living skills • Training and learning in the areas of employment skills, educational opportunities, hobbies and leisure activities • Development of self-advocacy skills, acquiring skills that enable an individual to exercise control and responsibility over services and supports received or needed • Activities that are directly related to the outcomes outlined in the Individualized Service Plan (ISP)
Activities Not Allowed	Day Services does not include the following situations: • Services furnished to a minor by the parent(s), step-parent(s) or legal guardian

- Services furnished to an individual by the person's spouse
- Services to individuals in Adult Foster Care or Children's Foster Care
- Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-142
- Services that are available under the Medicaid State Plan

Service Standards

Day Services must be reflected in the Individualized Support Plan (ISP)

- Services must address needs identified in the person centered planning process and be outlined in the ISP

Provider Qualifications

To be approved to provide Day Services, an applicant shall:

- Meet the requirements for direct care staff set out in 460 IAC 6-14-5 and 6-5-30
- An entity shall certify that, if approved, the entity will provide Day Services using only persons who meet the qualifications set out in 460 IAC 6-14-5

If providing an employment service an applicant shall also:

(1) Be accredited by, or provide proof of an application to seek accreditation from, one of the following organizations:

(A) Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor;

(B) The Council on Quality and Leadership in Supports for People with Disabilities, or its successor;

(C) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor;

(D) The National Commission on Quality Assurance, or its successor; or

(E) An independent national accreditation organization approved by the Secretary of FSSA

Documentation Standards

Day Services documentation must include:

Documentation for Billing:

- Approved provider
- The provider must use the approved participant attendance record. Each entry must include the initials of the individual who completes the daily entry. The provider maintains a list of staff who complete the form listing staff name and initials used.

Clinical/Progress Documentation:

- The provider completes a monthly summary of the individual's progress towards outcomes, using the approved form. This is a narrative summary, about one page in length, that describes the individual's day service activities, and must address outcomes in the individual's ISP, as well as a high level summary of issues affecting the health, safety and welfare of the individual requiring intervention by a healthcare professional, case manager, behavior support services provider or BDDS staff member.
- This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider agreement and reimbursement for services will not be available.

Residential Habilitation And Support Services	Residential Habilitation and Support service providers are responsible for the health, safety and welfare of the individual, and assist in the acquisition, improvement, and retention of skills necessary to support individuals to live successfully in their own homes
Unit of Service	Daily rate based on the needs of the individual
Activities Allowed	Residential Habilitation and Support services activities include direct supervision, monitoring and training to implement the Individualized Support Plan (ISP) outcomes for the individual through the following: • Assistance with personal care, meals, shopping, errands, chore and leisure activities and transportation (excluding transportation that is covered under the Medicaid State Plan) • Coordination and facilitation of medical and non-medical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, utilization of available supports in a cost effective manner and maintenance of each individual's health record • Assurance that direct service staff are aware and active participants in the development and implementation of ISP and Behavioral Support Plans
Activities Not Allowed	Residential Habilitation and Support services do not include the following situations: • Services furnished to a minor by the parent(s), step-parent(s) or legal guardian • Services furnished to an individual by the person's spouse • Services to individuals in Adult Foster Care or Children's Foster Care • Services that are available under the Medicaid State Plan

- Services furnished to an adult individual by a parent, step-parent or guardian, that exceed forty (40) hours per week

Service Standards

Residential Habilitation and Support services must be reflected in the Individualized Support Plan (ISP)

- Services must address needs identified in the person centered planning process and be outlined in the ISP

- Providers of Residential Habilitation and Support services must meet the training requirements for employees set out in 460 IAC 6-14-4

Provider Qualifications

To be approved to provide Residential Habilitation and Supports an applicant shall:

- Meet the requirements for direct care staff set out in 460 IAC 6-14-5

- An entity shall certify that, if approved, the entity will provide Residential Habilitation and Support services using only persons who meet the qualifications set out in 460 IAC 6-14-5, 6-5-30 and 6-5-14

Documentation Standards

Residential Habilitation and Support services documentation must include:

Documentation for Billing:

- Approved provider
- The provider must use the approved participant attendance record. Each entry must include the initials of the individual who completes the daily entry. The provider maintains a list of staff who complete the form listing staff name and initials used.

Clinical/Progress Documentation:

- The provider completes a monthly summary of the individual's progress toward outcomes, using the approved form. This is a narrative summary, about one page in length, that describes the individual's residential habilitation supports activities, and must address outcomes in the individual's ISP, as well as a high level summary of issues affecting the health, safety and welfare of the individual requiring intervention by a healthcare professional, case manager,

behavior support services provider or BDDS staff member.

- This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider agreement and reimbursement for services will not be available.

Case Management Services	Case Management Services means services that enable an individual to receive a full range of appropriate services in a planned, coordinated, efficient, and effective manner
Unit of Service	Annual rate for the provision of Annual Level of Care determination and re-determination Monthly rate for the provision of ongoing services
Activities Allowed	Case Management activities include: • Monitoring of services as outlined in 460 IAC 6-19-6 • Face-to-face contacts between the case manager and individual as required by 460 IAC 6-19-6(g) and (h) • Developing, updating, and reviewing Individualized Support Plan (ISP) using Person Centered Planning Process • Completing and processing annual Level of Care • Developing annual Cost Comparison Budgets using State approved process. • Disseminating information and forms to the individual and the Individualized Support Team (IST) • Incident report completion, submission and follow-up using State approved process • Monitoring of service delivery and utilization via telephone calls, home visits and team meetings • Monitoring consumer satisfaction and service outcomes • File maintenance • Acting as an agent for the individual to assure the interests and preferences of the individual are represented across all environments; and

strengthening informal and natural supports for each individual

- The negotiation of the best solutions resource identification and other individual or system needs

Activities Not Allowed

Reimbursement is not available through Case Management Services including but not limited to, the following situations:

- Services delivered to an individual who does not meet eligibility requirements established by BDDS
- Counseling services related to legal issues. Such issues shall be directed to the Indiana Advocacy Services, the designated Protection and Advocacy agency under the Developmental Disabilities Act and Bill of Rights Act, P.L. 100-146
- A person related through blood or marriage to any degree to an individual may not conduct case management for that individual

Service Standards

Case Management Services shall be reflected in the ISP

- Provision of services must comply with 460 IAC 6-19
- Case Management Services must be included as a service in the ISP the Cost Comparison Budget (CCB)

Provider Qualifications

To be approved to provide Case Management Services as a **Level 1 Case Management Services Provider,** an applicant shall meet the following requirements:

- (1) Have a bachelor's degree, be a registered nurse licensed under IC 25-23-1, or be employed by the State in a PAT III position
- (2) Meet the experience requirements for qualified mental retardation professional in 42 CFR 483.430(a)
- (3) Complete a course of Case Management Orientation that is approved by DDRS
- Have not been de-certified by the State
- Must be in good standing with the State

To be approved to provide Case Management Services as a **Level 2 Case Management Services Provider,** an applicant shall meet the following requirements**:**

- (1) Have at least a four year college degree with no direct care experience; or
- (2) Have a high school diploma, or equivalent, and have at least five (5) years experience working with persons with mental retardation or other developmental disabilities; and
- (3) Be supervised by a Level 1 Case Management Services Provider who is supervising no more than four (4) other Level 2 Case Management Services Providers
- (4) Complete a course of Case Management Orientation that is approved by the DDRS

- Have not been de-certified by the State

- Must be in good standing with the State

For an entity to be approved to provide Case Management services, the entity shall:

- Certify that, if approved, the entity will provide Case management services using only persons who meet the qualifications set out in 460 IAC 6-5-5

Documentation Standards

Case Management Services documentation includes:

Documentation for Billing:

- Approved provider
- Must provide documentation identifying them as the case manager of record for the individual (the pick list is appropriate documentation)

Clinical/Progress Documentation:

- Documentation in compliance with 460 IAC 6-19
- Documentation must be entered into the electronic data system within seven (7) days of the provision of services

This service definition is effective 11-01-05
This service definition supersedes all previous definitions of this service

ATTACHMENT B: Billing Codes

New Service Codes Effective 11/1/2005 **Current Service Codes to Be End Dated 10/31/2005**

Waiver			Annual Plan Service Information		New Service Codes			Current Waiver Service Information		
A	DD	SS	Sub Code	Waiver Service Title	Code (Modified)	Unit		Sub Code	Waiver Service Title	Code
X	X		RHSD	Residential Habilitation and Supports - Daily	T2016 U7	1	Day	RHS1	Residential Hab/Support - Level 1 - Under 35 Hours/Week	T2017 U7
								RHS2	Residential Hab/Support - Level 2 - Under 35 Hrs/Wk - QMRP	T2017 U7 TF
								RHS3	Residential Hab/Support - Level 3 - Over 35 Hours/Week	T2017 U7 TG
								IAS	Independence Assistance Services - Hourly	T2017 U7 U1
								TLV1	Transportation - Level 1 - 24 Hour	T2004 U7 U1
								TLV2	Transportation - Level 2 - 24 Hour	T2004 U7 U2
								T1ST	Transportation - 1st Round Trip of Day - Residential	T2004 U7 U3
								T2ND	Transportation - 2nd Round Trip of Day - Residential	T2004 U7 U4
								HCC1	Health Care Coordination - Level 1	T2022 U7 U1
								HCC1	Health Care Coordination - Level 2	T2022 U7 U2
								HCC1	Health Care Coordination - Level 3	T2022 U7 U3
								HCC1	Health Care Coordination - Level 4	T2022 U7 U4
								CHPI	Community Hab & Part - Community-Based - Individual	T2021 U7
X	X	X	DSRV	Day Services	T2020 U7	1	Day	CHPG	Community Hab & Part - Community-Based - Group	T2021 U7 HQ
								CHPR	Community Hab & Part - Faciltity-Based - Group	T2021 U7 UA HQ
								CHPF	Community Hab & Part - Facility-Based - Individual	T2021 U7 UA
								HPV	Pre-Vocational Services	T2015 U7
								HSE	Supported Employment	H2023 U7
								TD1	Transportation - 1st Round Trip of Day - Day Service	T2004 U7 U6
								TD2	Transportation - 2nd Round Trip of Day - Day Service	T2004 U7 U8
								CHPI	Community Hab & Part - Community-Based - Individual	T2021 U7
X	X	X	BMGT	Behavior Management - Basic; Monthly	H0046 U7	1	Mnth	BMAN	Behavior Management	H0004 U7 U2
X	X	X	BMG1	Behavior Management - Level 1; Monthly	H0046 U7 U1	1	Mnth	BMN1	Behavior Management - Level 1	H0004 U7 U1
X	X	X	CMAN	Case Management; Monthly	T2022 U7	1	Mnth	CMGT	Case Management	T1016 U7
								PCPO	PCP/ISP Facilitation - Ongoing	T2024 U7 TS
X	X	X	CMNA	Case Management; Annual Plan Facilitation	T2024 U7 U1	1	Unit	PCPI	PCP/ISP Facilitation - Initial	T2024 U7

Waiver			Annual Plan Service Information		New Service Codes			Current Waiver Service Information		
A	DD	SS	Sub Code	Waiver Service Title	Code (Modified)	Unit		Sub Code	Waiver Service Title	Code
NO CHANGE (Carryover from last approved CCB):										
X	X		AF1	Adult Foster Care - Level 1- Day	S5141 U7 U1	1	Day	AF1	Adult Foster Care - Level 1- Day	S5141 U7 U1
X	X		AF2	Adult Foster Care - Level 2- Day	S5141 U7 U2	1	Day	AF2	Adult Foster Care - Level 2- Day	S5141 U7 U2
X	X		AF3	Adult Foster Care - Level 3- Day	S5141 U7 U3	1	Day	AF3	Adult Foster Care - Level 3- Day	S5141 U7 U3
X	X	X	ADS1	Adult Day Service - Level 1 (1/2 Day)	S5101 U7 U1	0.5	Day	ADS1	Adult Day Service - Level 1 (1/2 Day)	S5101 U7 U1
X	X	X	ADS2	Adult Day Service - Level 2 (1/2 Day)	S5101 U7 U2	0.5	Day	ADS2	Adult Day Service - Level 2 (1/2 Day)	S5101 U7 U2
X	X	X	ADS3	Adult Day Service - Level 3 (1/2 Day)	S5101 U7 U3	0.5	Day	ADS3	Adult Day Service - Level 3 (1/2 Day)	S5101 U7 U3
X	X	X	AS14	Adult Day Service - Level 1 (1/4 Hour)	S5100 U7 U1	0.25	Hour	AS14	Adult Day Service - Level 1 (1/4 Hour)	S5100 U7 U1
X	X	X	AS24	Adult Day Service - Level 2 (1/4 Hour)	S5100 U7 U2	0.25	Hour	AS24	Adult Day Service - Level 2 (1/4 Hour)	S5100 U7 U2
X	X	X	AS34	Adult Day Service - Level 3 (1/4 Hour)	S5100 U7 U3	0.25	Hour	AS34	Adult Day Service - Level 3 (1/4 Hour)	S5100 U7 U3
X	X	X	RNUR	Respite Nursing	T1005 U7 UA TD	0.25	Hour	RNUR	Respite Nursing	T1005 U7 UA TD
X	X	X	RNUR	Respite Nursing	T1005 U7 UA TE	0.25	Hour	RNUR	Respite Nursing	T1005 U7 UA TE
X	X	X	RATT	Respite - Attendant Care	S5150 U7 UA UC	0.25	Hour	RATT	Respite - Attendant Care	S5150 U7 UA UC
X	X	X	RATT	Respite - Attendant Care (Non-agency, individual)	S5150 U7 UC	0.25	Hour	RATT	Respite - Attendant Care (Non-agency, individual)	S5150 U7 UC
X	X	X	GRES	Respite Group	S5150 U7 HQ	0.25	Hour	GRES	Respite Group	S5150 U7 HQ
X	X	X	RHHA	Respite - Home Health Aide	S5150 U7 UA U9	0.25	Hour	RHHA	Respite - Home Health Aide	S5150 U7 UA U9
X	X	X	PHTH	Physical Therapy	G0151 U7 UA	0.25	Hour	PHTH	Physical Therapy	G0151 U7 UA
X	X	X	SPTH	Speech Therapy	92507 U7 UA	0.25	Hour	SPTH	Speech Therapy	92507 U7 UA
X	X	X	OCTH	Occupational Therapy	G0152 U7 UA	0.25	Hour	OCTH	Occupational Therapy	G0152 U7 UA
X	X	X	PSTF	Psychological Therapy - Family	90846 U7	0.25	Hour	PSTF	Psychological Therapy - Family	90846 U7
X	X	X	PSTG	Psychological Therapy - Group	90853 U7	0.25	Hour	PSTG	Psychological Therapy - Group	90853 U7
X	X	X	PSTI	Psychological Therapy - Indiivdual	90804 U7	0.25	Hour	PSTI	Psychological Therapy - Indiivdual	90804 U7
X	X	X	MUTH	Music Therapy	H2032 U7 U1	0.25	Hour	MUTH	Music Therapy	H2032 U7 U1
X	X	X	RETH	Recreational Therapy	H2032 U7 U2	0.25	Hour	RETH	Recreational Therapy	H2032 U7 U2
X	X		R&F	Rent & Food for Unrelated Live-In Caregiver	T2025 U7	1	Mnth	R&F	Rent & Food for Unrelated Live-In Caregiver	T2025 U7
X	X	X	ADST	Transportation - Adult Day Service	T2003 U7	1	Trp	ADST	Transportation - Adult Day Service	T2003 U7
X	X	X	PRSM	Personal Emergency Response System - Maintenance	S5161 U7	1	Mnth	PRSM	Personal Emergency Response System - Maintenance	S5161 U7
Carryover for initial Conversion CCBs ONLY - Added by CM (w/approval) to Annual CCBs										
X	X	X	CRIS	Crisis Intervention	T2034 U7	1	Day	CRIS	Crisis Intervention	T2034 U7
X	X		CT	Community Transition	T2038 U7	1	Unit	CT	Community Transition	T2038 U7
X	X	X	FCAR	Family & Caregiver Training - Family	S5111 U7	1	Unit	FCAR	Family & Caregiver Training - Family	S5111 U7
X	X	X	FCNF	Family & Caregiver Training - Non-Family	S5116 U7	1	Unit	FCNF	Family & Caregiver Training - Non-Family	S5116 U7
X	X	X	INSP	E-Mod/Spec Med Equip & Sup - Assess/Inspect/Train	T1028 U7	0.25	Hour	INSP	E-Mod/Spec Med Equip & Sup - Assess/Inspect/Train	T1028 U7
X	X		EMOI	Environmental Modification - Install	S5165 U7 NU	1	Unit	EMOI	Environmental Modification - Install	S5165 U7 NU
X	X		EMOM	Environmental Modification - Maintenance	S5165 U7 RP	1	Unit	EMOM	Environmental Modification - Maintenance	S5165 U7 RP
X	X	X	ATCH	Specialized Medical Equipment/Supplies - Install	T2029 U7 NU	1	Unit	ATCH	Specialized Medical Equipment/Supplies - Install	T2029 U7 NU
X	X	X	ATCM	Specialized Medical Equipment/Supplies - Maintenance	T2029 U7 RP	1	Unit	ATCM	Specialized Medical Equipment/Supplies - Maintenance	T2029 U7 RP
X	X	X	VMOD	Vehicle Modification - Install	T2039 U7	1	Unit	VMOD	Vehicle Modification - Install	T2039 U7
X	X	X	PRSI	Personal Emergency Response System - Install	S5160 U7	1	Unit	PRSI	Personal Emergency Response System - Install	S5160 U7

ATTACHMENT C: Billing Information

The new billing methodology represents a shift from paying for specific staff time in ¼ hour units, to one that allows for more flexibility on the part of the ISP and encourages creativity in the provision of services.

Before the new rates are distributed the week of September 26, 2005, we will do our best to assure that the information is accurate. However, we understand that with an undertaking of this magnitude, inaccuracies may result. When rates are distributed, we will provide direct contact information to a designated state work group that will be available to review errors. This process will not be used to negotiate rates.

For RHS and Day Services that are now per diem units, billing will be based on enrollment with a provider. When the provider receives the approved NOA, confirming they are the provider of services and listing the per diem, they may begin daily billing. You should bill for each day, regardless of whether or not the person receives services on that specific day. For example, Day Service providers will bill every day of the week (Saturday through Sunday) for those individuals enrolled with them, regardless of whether they participate in services M-W-F, or Monday through Friday, or just on Tuesdays, or if they decide to stay home on one of their regular service days. Enrollment with the provider is the key in determining when to bill the per diem services.

Similarly, enrollment determines whether or not Case Managers or Behavior Specialists bill for monthly services. If the individual is enrolled with you as the provider, you bill once for the entire month, whether you see the individual once during the month or daily. Services provided should meet the needs of the individual and should not depend on the approval of a new CCB. Those months when an individual needs limited Case Management or Behavior Management services, you bill the same monthly unit and amount as you would in months when the individual needs more services. For case managers, the Annual Level of Care Determination unit can be billed once during the Annual CCB period. Case Managers may not bill for this service until the Annual Level of Care Determination is complete.

The only circumstances in which a provider cannot bill for an individual they have enrolled is when the individual enters a nursing facility and their Level of Care changes, or when the circumstances are met that require the individual to be terminated from the waiver.

ATTACHMENT D: Sample Forms

The attached Attendance Form is the record the Residential and Day Service providers will use to show when an individual attends services. The information is intended to serve as documentation of attendance of the individual, not staff. There should be one entry per day the individual is in attendance.

The second form is the monthly summary for the individual. This is to be used by Residential and Day Service providers in place of daily notes previously required. The monthly summary is to be used for documenting significant events during the month and describing progress made towards the individual's outcomes. Please see the Documentation sections of the service definitions in Attachment A for further information.

This form does not take the place of the seizure management log nor does it replace documentation needed for the Functional Behavioral Assessment or the Behavioral Support Plan.

WAIVER PARTICIPANT ATTENDANCE RECORD

Service: RHS____ Day Services____ (Mark only one; must use separate form for each service)

Directions: Place an "X" or checkmark in date frame to signify that participant was present on that date. The staff person (not the billing staff) completing the form must initial under the "X" or checkmark.

Example:

Date: 11/1
X / JG

Providers will bill for each day of the month; this is merely an attendance record.

MONTH_____

Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Date:	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Date:	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Date:	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Date:	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Date:	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Date:	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**

WAIVER PARTICIPANT STATUS MONTHLY SUMMARY

NAME OF CONSUMER_____ RID #_____

MONTH_____ YEAR_____ WAIVER SERVICE: RHS___ Day Service___

NOTE: Separate summaries are required for RHS and Day Services. Use separate form for each service. This summary should include consumer's progress toward major goals as measured by a metric, if any, as documented in the ISP.

Signature of QMRP who reviewed summary_____

Date _____